UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RESTASIS (cyclosporine)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

I. Approved for the following diagnoses (ICD.9)

370.20 Superficial keratitis, unspecified
370.21 Punctate keratitis
370.33 Keratoconjunctivits sicca, not specified as Sjogren's disease
710.2 Sicca syndrome- Sjogren's disease

Documentation requirements for the above diagnoses:

1. Diagnosis
2. Documented fluorescien test.
3. Request from ophthalmologist or with documented ophthalmologist consult

AUTHORIZATION:

Prior approval for the above diagnosis is for 1 year.

RE-AUTHORIZATION:

Additional periods require steps 1-3

II. Restasis for Post Corneal Transplant (ICD.9)

V 42.5 Post Corneal Transplant

Documentation of post corneal transplant:

1. Diagnosis only

AUTHORIZATION:

Prior approval is for 1 year

RE-AUTHORIZATION:

Telephone call from physician's office

INFORMATION:

Maximum supply is 1 box of 32 dropperetts/month